BEFORE THE
OFFICE OF ADMINISTRATIVE HEARINGS
STATE OF CALIFORNIA

In the Matter of: GE "GABRIEL" L., Claimant, vs. HARBOR REGIONAL CENTER, Service Agency.	OAH No. 2010031141

DECISION

This matter was heard by Julie Cabos-Owen, Administrative Law Judge with the Office of Administrative Hearings, on August 3, 2011, in Torrance, California. Ge "Gabriel" L. (claimant) was represented by Ping Z., his mother and authorized representative, who was assisted by a family friend, Sam F.[1] Harbor Regional Center (HRC or Service Agency) was represented by its Manager of Rights Assurance, Gigi Thompson.

Oral and documentary evidence was received, and argument was heard. The record was closed, and the matter was submitted for decision on August 3, 2011.

ISSUE

Does Claimant have a developmental disability which makes him eligible for regional center services?

[1] Claimant's and his representatives' initials are used, in lieu of their last names, to protect their privacy.

FACTUAL FINDINGS

1. Claimant is a 23-year-old male (born February 16, 1988). He claims to be eligible for regional center services based upon a diagnosis of Autism. (Testimony of Ping Z.; Exhibit A.)

2. Claimant is an only child who was raised primarily by his mother and maternal grandmother. He was born in China and lived there with his parents and grandparents until he moved to Argentina with his mother and grandmother at age 10. They later moved to the United States when claimant was 14 years old. (Exhibit O.)

3. Mandarin Chinese is claimant's primary language, but he learned to speak and read Spanish with limited proficiency during his time in Argentina and learned English with limited proficiency. (Exhibit O.)

4. His developmental milestones were met within normal limits. However, at a very young age he displayed a significant lack of eye contact. He also had few social interactions with peers and had no friends. At age three, claimant would hide behind his mother whenever other people were around. (Exhibit O.)

5. During claimant's time in Argentina, his grandmother took care of him and met all of his daily needs, and claimant was completely reliant on her. In Argentina, claimant's social interactions continued to be impaired, with a significant lack of eye contact with others. He had no friends and had difficulty getting along with his teachers. He attended school in Argentina until the end of seventh grade. Eighth grade became a turbulent time for claimant, as he was shuttled back and forth between China, Argentina and the United States.[2] (Exhibit O.)

6. Claimant moved to California with his grandmother and mother during the fall of ninth grade, but did not start attending high school until November. During this year, claimant became obsessed with video games and refused to interact socially. He had no friends at his high school and would become easily scared of his peers. (Exhibit O.)

7. In about February or March 2003, his family moved to another city in California, and claimant was resistant to attending his new high school. The other children teased him, and he began working on Kung Fu after school. He also became paranoid about teachers making any physical contact with him, including patting his back. (Exhibit O.)

[2] Much of claimant's childhood history is unclear. Although HRC received two typewritten documents in claimant's eligibility packet which were purportedly statements by claimant's grandmother, translated into English (Exhibits H and L), claimant's mother denied knowing the origin of the documents and challenged their veracity. Given the lack of authentication, the statements contained in the documents were not considered in determining claimant's eligibility for regional center services.

8. In April 2003, claimant's mother left on an out-of-state business trip but was called back by claimant's grandmother, who reported that claimant was becoming increasingly violent and had punched a hole in the wall and hit her with a stick. Claimant stated that he saw ghosts and spirits following him and had used the stick to beat them away. Thereafter claimant refused to go to school, and had another instance of physical violence in May 2003 when he punched his mother. (Exhibit O.)

9. In June 2003, claimant's mother sent him to Michigan to stay with his uncle. However, claimant became increasingly paranoid and ate his meals alone.

10. In July 2003, he was hospitalized for one week at the Child and Adolescent Psychiatric Hospital at the University of Michigan (CAPH) while he was staying with his uncle for the summer. He presented with paranoid ideation, delusions, disorganization, visual and auditory hallucinations and unprovoked violence. He was diagnosed with psychosis, NOS, and was prescribed antipsychotic medication. He returned to California and continued treatment with Dr. Julia Lam. (Exhibit O.)

11 (a). In September 2003, when Claimant was 15 years old, he was referred by CAPH for a psycho-educational assessment conducted by his school district to determine his eligibility for special education services. The referral was made due to concerns about claimant's mental health status and its impact on his performance in a general education classroom. Claimant had never received special education services prior to 2003. (Exhibit O.)

11(a). During the psycho-educational assessment, the evaluator noted:

> [Claimant] appeared to be somewhat shy with the examiner initially, but began asking the examiner questions of a personal nature almost immediately after sitting down to begin the assessment. For instance, he repeatedly asked the examiner how old she was, and also asked her what her salary was. He also repeatedly complimented the examiner by saying that she was "pretty." When the examiner did not give him a satisfactory response to any of his questions, [claimant] would insist on asking those same questions until it was very evident that he would not be getting any answers that he wanted. Throughout the testing sessions, [claimant] had very minimal eye contact with the examiner and would typically talk to her while looking down at the table. However, [claimant] was extremely articulate and his expressive communication was very fluent. It was noticed, however, that [claimant] tended to perseverate on certain topics during his conversation. For instance, [claimant] repetitively brought up themes of paranoia towards people who are "bad." He exhibited deep distrust of people and also brought up a deep desire to want to make friends, as well as feelings of loneliness and boredom. He kept asking the examiner if she was his friend, and appeared happy when she was his

> friend, and appeared happy when she replied positively to him.
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> [Claimant] put in good effort on all of the assessment tasks. He appeared motivated to do well, and his effort was consistent. He was able to work for extended periods of time without taking breaks, even though breaks were offered to him several times. He stated that he enjoyed doing the assessment tasks. He typically worked silently and responded well to encouragement. [Claimant] was able to remain attentive to the test items and demonstrated the ability to concentrate for long periods of time. I was observed that [claimant] would occasionally rock back and forth during the assessment as he is thinking about the answers. During the second session, [claimant] appeared to be more tired than the first session due to the earlier testing time. He also remarked that he was tired because of his medication. However, [claimant] was still able to demonstrate good effort and worked hard on the assessment tasks. Overall, [claimant] was compliant and worked very well with the examiner. He seemed to feel comfortable with the examiner and responded well to encouragement. (Exhibit O.)

11(b). At the time of the evaluation, claimant still believed that there were spirits and ghosts in his house and there were evil eyes watching him. When interviewed by the examiner, claimant claimed that he could interpret the Bible because God comes to help him; claimant would not provide details because "it's a secret." During the interview his paranoia was evident to the evaluator. (Exhibit O.)

11(c). Administration of the Leiter-R revealed that claimant achieved a Full Scale IQ of 92. Application of the Asperger's Syndrome Diagnostic Scale (ASDS) indicated that claimant had a likely probability of having Asperger's Syndrome. (Exhibit O.)

11(d). The evaluator noted:

> Results from the ASDS indicate that [claimant] exhibits many characteristics typically associated with individuals who have Asperger Syndrome. For instance, in terms of language, [claimant] would talk excessively about favorite topics (comic books, the Bible, video games) that hold limited interest for others. He also has a tendency to ask inappropriate questions (i.e., about one's age or salary), and frequently acts as though he understands more than he does. On the Social subscale, [claimant] displays limited eye contact with others, and also has difficulty relating to other people. He has no friends in spite of a desire to have them, and has not shown the ability to maintain friendships. [Claimant] also has a difficult time adjusting to new environments, and displays behaviors that appear to be immature for his age. He also engages in repeated and obsessive behavior on a

> frequent basis (chanting, leaving water in a bottle or cup as described previously). In regards to cognition, [claimant] appears to be aware that he is different from others and has an average to above average intelligence. He also displays weak executive functions in relation to planning and organizational abilities. [Claimant] also responds negatively or inappropriately to being touched by other people, and also displays unusual reactions to things that irritate him (i.e., chanting gibberish to ward off 'evil spirits').
>
> [¶ . . . ¶]
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> Overall, responses indicate that [claimant] is most adept in his communications skills per his mother's report. He is able to articulate and describe in detail personal experiences, events, and stories. He is able to express himself adequately using written language. [Claimant] appears to have more difficulty in the adaptive areas related to Daily Living Skills and Socialization. Although he is able to care for all his toileting, grooming, and feeding needs, [claimant's] mother reports that she still cuts his fingernails for him. He does not straighten his room on his own, and also does not make his own bed. [Claimant] also does not have experience with budgeting or regulating monetary issues, as he does not get an allowance on a regular basis. In terms of Socialization, [claimant] is unable to initiate and maintain friendships with peers, and does not always respond appropriately when questions of others that are perceived as being too personal. Overall, as is consistent with individuals who have Asperger Syndrome, [claimant] demonstrates a weakness in exhibiting age-appropriate Socialization Skills, with the age-equivalence for Socialization at the 7 years, 9 months level. (Exhibit O.)

11(e). The evaluator concluded:

> [Claimant] appears to present with Major Depression, with evidence of psychotic tendencies which include periodic auditory and visual hallucination, as well as unrealistic thoughts and significant paranoia. He also appears to exhibit characteristics of an individual undergoing Post-traumatic Stress Disorder, as well as characteristics of an individual with Asperger Disorder. (Exhibit O.)

12(a). From December 21, 2003, through January 18, 2004, claimant was admitted to the University of California, Los Angeles (UCLA) Neuropsychiatric Institute Hospital (NPIH) due to increasing psychotic symptoms and unprovoked aggressions towards family members. In a written report, his attending psychiatrist, Mark DeAntonio, M.D., and Child and Adolescent Psychiatry Fellow, Nancy Wu, M.D., noted:

> During his hospital stay, [claimant] isolated himself in his room and spent hours reading the Bible even though, given his limited English ability, he most likely did not understand the content. When approached, he would often hide under his blanket and refuse to engage with the psychiatrist. Staff noted that [claimant] would ask staff members to hit him on the chest in order for him to become stronger. [Claimant] also reported that he was unable to see the sun from his room and therefore could no longer talk to it. During occupational and recreational therapy group activities, [claimant] typically sat by himself and would play basketball by himself. When the psychiatrist tried to engage and play with him, [claimant] would often walk away. In the hospital milieu, it was noted that [claimant] had very poor eye contact and deficient social skills and that he would often interact with others in a child-like manner. He tended to greet staff by gesturing with a peace sign; however, even after the initial greeting, [claimant] would continue to hold the peace sign as he walked away. He was noted to have extremely poor social skills and adaptive functioning skills. He was observed to put leftover food in his dresser drawers; despite repeated requests from staff for him to clean his room, [claimant] does did not appear to know how to fold his clothes or make his bed. (Exhibit Y.)

12(b). Claimant was diagnosed with Schizophrenia and Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS). (Exhibit Y.)

13. On September 21, 2004, claimant was voluntarily placed at Metropolitan State Hospital for evaluation and treatment after being arrested and placed in juvenile hall for assault and battery on his grandmother in July 2004. He had attacked her because he believed that she was the devil. She was able to run outside the home, but he followed her and continued hitting her until a police officer on patrol witnessed the incident and subdued him. After his admission to Metropolitan State Hospital, claimant continued to have paranoid delusions. (Exhibits F and V.)

14(a). In a September 2005 annual psychological evaluation, Dr. Wang from Metropolitan State Hospital noted his mental status as follows:

> [T]he patient is still anxious and restless from time to time but is able to follow verbal commends and verbal direction. The patient has inappropriate social behavior by touching staff inappropriately. Most of the time, he is cooperative. His speech is spontaneous but kind of slow. The patient is selectively mute and he does not answer questions. . . . He continues to have paranoid delusion. . . . He is alert, awake and oriented to person, place and concentration is impaired. Memory is intact. The abstraction is concrete. The insight is poor and judgment is impaired. The impulse control is poor. The patient has disorganized

> thoughts from time to time. The patient's grooming is poor. . . . He needs to be prompted to eat and to perform daily activities. (Exhibit X.)

14(b). Claimant's diagnosis was Schizophrenia, paranoid type. (Exhibit X.)

15(a). In December 2005, Steve Yang, Psy.D., conducted a Psychological Assessment of claimant at the Metropolitan State Hospital. His assessment included the administration of the Gilliam Asperger's Disorder Scale (GADS) and the Vineland Adaptive Behavior Scales (Vineland). On the Vineland, his scores were in the low range. Dr. Yang noted:

> These results indicate that while [claimant's] adaptive behavior skills are significantly depressed due to his current psychotic symptoms, [claimant] had deficits in his adaptive functioning prior to the onset of his schizophrenia. As some deficits existed prior to the onset of his mental illness, these deficits would likely remain when his psychotic symptoms go into remission. (Exhibit W.)

15(b). Claimant's score on the GADS indicated that it was highly probable that he had suffered from Asperger's Disorder since he was five to six years old. According to Dr. Yang:

> Information gathered from the interview with [claimant's] mother reveals that many of [claimant's] social deficits existed since his early childhood, prior to the onset of his psychotic symptoms. [Claimant] was described to be a socially isolative child who had little awareness of social conventions. He avoided eye contact with others and did not use non-verbal behaviors to regulate social interaction with others. Despite these handicaps, [claimant] was demonstrably intelligent. He has advanced math skills and has been able to learn both Spanish and English since he moved out of China 7 years ago.
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> [Claimant] had few interests in life and tends to engage excessively in those interests. [Claimant] paced around incessantly, especially when upset. He frequently engaged in repetitively chanting a specific phrase in Mandarin. [Claimant] also exhibited adherence to some specific non-functional rituals (i.e., insisting on walking along all 4 walls of the room before leaving it and walking in circles around a pole before walking past it.) [Claimant's] behaviors had been present since an early age and were consistent with individuals diagnosed with Asperger's Disorder. (Exhibit W.)

15(c). Dr. Yang diagnosed claimant with Schizophrenia, paranoid type, and Asperger's Disorder. He recommended that claimant be referred to the regional center to seek additional services.

16. In February 2006, claimant requested an eligibility determination through San Gabriel Pomona Regional Center. Later that month, the case was transferred to HRC, since claimant was scheduled to be moved from Metropolitan State Hospital (where he had been since 9/21/04) to a mental health facility named La Casa Mental Health Rehabilitation Center (La Casa) in Long Beach after turning age 18 on February 16. (Exhibit F.)

17(a). On February 16, 2006, claimant was discharged from Metropolitan State Hospital to La Casa for continuing treatment. His diagnoses on discharge were Schizophrenia, undifferentiated type, and Asperger's Disorder. (Exhibit V.)

17(b). A Summary Response to Treatment and Recommendations for Aftercare from Metropolitan State Hospital summarized claimant's progress during his admission as follows:

> Initially, the discharge plan was that [claimant] would be discharged to a less restrictive setting after he met discharge criteria. Unfortunately, [claimant] was never able to meet discharge criteria. Although there had been sporadic improvements since admission, it was difficult for [claimant] to maintain his improvements for a significant amount of time. There were also several unsuccessful trials of medications and recently, a secondary diagnosis of Aspbergers [*sic*] added to his primary diagnosis of schizophrenia. [Claimant] struggled in identifying what his goals are in regards to treatment. He often stated that he wanted to go home with his Mom and constantly stated he would like to leave the hospital. He continued to talk about unseen stimuli such as ghosts and people "seducing him" and his delusions were barriers to reality-based conversations in regards to discharge planning. In addition, during the past three months, [Claimant's] ritualistic/preservative [*sic*] behaviors significantly increased. A strength was that [Claimant] was more expressive and responsive and treatment participation had been satisfactory. However, basic objectives specified in wellness and recovery plan were not met. (Exhibit U.)

18(a). In June 2006, Rita S. Eagle, Ph.D., conducted a psychological assessment of claimant. This assessment included a review of claimant's records (including those from Metropolitan State Hospital and La Casa), and a translated interview with claimant's mother. (Exhibit G.)

18(b). During her first attempt at interviewing claimant, Dr. Eagle noted that he appeared heavily sedated and unresponsive. His head was down, he was drooling, his breathing was heavy, and he had a twitching or tremor in one arm and hand. Dr. Eagle attempted to engage him in conversation, but he did not change his presentation. Dr. Eagle was unable to complete an assessment that day. However, when she stood up to leave, claimant offered her half of the sandwich and a bag of chips from the lunch he was eating, and he smiled and made brief eye contact with her as he handed her the bag of chips. He also accepted a goodbye handshake from Dr. Eagle. (Exhibit G.)

18(c). The second meeting with claimant took place with his mother present. Upon entering the room, claimant offered Dr. Eagle some food that he had been eating. He made brief eye contact when he offered it. He sat down at his mother's side and turned his body to face and her watch her fixedly as she spoke. Dr. Eagle noted:

> [Claimant] seemed less sedated, more alert and happier during this session. However he was still mute, slow in his movements, drooled, and did not engage with the examiner. His attention seemed riveted on his mother, who however was engaged in talking to the psychologist . . . and did not, spontaneously, direct her attention to [claimant]. At one point, [claimant] moved closer to her and put his arm around her. When the interview was over, [claimant] shuffled as fast as he could to keep up with his mother as she left the room and then leaned heavily on her, as if a little child. (Exhibit G.)

18(d). Dr. Eagle further noted:

> Metropolitan State Hospital referred [claimant] to the regional center due to the supposition that [claimant] had an autistic spectrum developmental disability in addition to, antecedent to, and underlying his current psychosis. Unfortunately, at this point, the features of [claimant's] psychosis and the effects of medication preclude evaluation of his pre-morbid psychological functioning. [Claimant's] medication regimen is in the process of being changed, so that an optimal degree of stabilization has not been achieved. Indeed, it appears that [claimant's] functioning has not been stabilized over at least the past three years.
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> [Claimant's mother and his grandmother] have provided a history (including a description of [claimant's] pre-morbid adaptive functioning) that, for the most part, is not inconsistent with an autistic spectrum disorder. However, it cannot be considered conclusive. Not only can there not be, at this time, clinical observation to corroborate the speculation, the historical information may not be entirely reliable and/or raises the possibility of alternative diagnoses. . . . While it appears that [claimant] may have been different from other children

> from preschool on, it is not clear exactly what the differences were and the extent to which environmental factors may have played a role in either predisposing him to them, or exacerbating them. Questionable attachment history in infancy and repeated separations from significant caregivers, throughout his early childhood raise questions about separation anxiety, attachment disorder, or depression. Anxiety and depression in his early school years may have been inappropriately handled by school personnel; the multiple moves, in several countries, requiring accommodation to dramatic shifts in culture and language also may be exacerbating social difficulties in a temperamentally shy child.
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> Multiple trauma in [claimant's] early teens raise the possibility of post traumatic stress disorder or chronic adjustment disorder. Along with multiple moves, negative peer experiences and cultural changes, they may also have been predisposing or precipitating factors for his psychosis. [Claimant] also experienced a significant separation from his grandmother, arguably his primary attachment figure, during his adolescence around the time of his escalating psychosis. Her departure, return, and eventual disappearance may have been amongst the factors exacerbating his psychiatric condition.
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> It should be noted that virtually all of the questions on the Gilliam Asperger's Scale and the [Asperger's Syndrome Diagnostic Scale (ASDS)], might also be endorsed for a person with a psychotic disorder, and indeed several of the examples given for the characteristics endorsed on the ASDS were more suggestive of psychosis than Asperger's Syndrome. The Gilliam was administered when [claimant] was already actively psychotic and/or heavily medicated. . . .
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> In conclusion, it is the opinion of this psychologist that [claimant] cannot be assessed for regional center until and unless his psychosis is stabilized. Even if [claimant] does have an underlying developmental disability, its nature and severity cannot be determined at this time, and it does not appear, in any case, that services appropriate for developmental disabilities would meet his current needs. (Exhibit G.)

18(e). Dr. Eagle diagnosed claimant with Psychosis NOS, and deferred any further Axis I diagnosis. (Exhibit G.)

19. Given claimant's psychiatric instability as outlined in Dr. Eagle's report, the eligibility team decided to defer any eligibility decision. On August 31, 2006, HRC sent a letter to claimant's mother, informing her that they had determined claimant was not eligible for regional center services. (Exhibits C and D.)

20. On September 25, 2006, Dr. Eagle met with claimant, his mother, and a translator at La Casa to explain the eligibility decision. At that meeting, claimant seemed more verbal and in better social contact with others than he had been during Dr. Eagle's prior meetings with him, although he still appeared to be suffering from psychotic symptoms (e.g., delusions about demons pinching him; inappropriately engaging in loud prayer during the meeting) and medication effects (e.g. drooling). Dr. Eagle presented a detailed review of her report, and claimant asked, "What is autism?", indicating that he had been listening to Dr. Eagle's explanation of the assessment findings. She informed claimant's mother of her right to re-apply to HRC if and when he had improved such that his psychosis and/or side-effects of medication no longer occluded any underlying condition. (Exhibit D.)

21. In an April 9, 2008 Individualized Education Program (IEP), claimant was listed as eligible for special education services based on a primary disability of Emotional Disturbance and a secondary disability of Autism. However, the category of Autism for special education services encompasses all Autistic Spectrum disabilities, including Asperger's Disorder, as was indicated by the discussion about claimant's "Aspbergers" in the body of the IEP. (Exhibit N.)

22. On about September 22, 2008, claimant moved from LaCasa to a "Homes for Life Foundation" facility in Norwalk. (Exhibits Q and R.)

23. In June 2009, claimant's mother requested a re-assessment for eligibility. (Exhibit D.)

24(a). In October 2009, Dr. Eagle, conducted a psychological assessment of claimant. The assessment included a review of records the administration of various diagnostic tools for measuring cognitive functioning and adaptive skills and for ascertaining characteristics of Autism. (Exhibit K.)

24(b). To assess claimant's cognitive functioning, Dr. Eagle administered claimant the Wechsler Adult Intelligence Scale – Fourth Edition (WAIS-IV). Claimant obtained a standard score in the middle range of mild impairment on the Verbal Comprehension and Working Memory Indices, in the low average range on the Perceptual Reasoning Index, and at just at the cusp of the average range on the Processing Speed Index. His full scale score (a composite of all of the above-mentioned indices) fell at the border of the mild impairment and borderline ranges. (Exhibit K.)

24(c). In the area of adaptive functioning, Dr. Eagle administered the Vineland Adaptive Behavior Scales, Second Edition (VABS-II); Claimant's mother, his grandmother and Roanna Go, Supportive Services Coordinator for Homes for Life, with the assistance of a translator, provided the responses necessary for the completion of this test. Claimant's VABS-II scores placed him in the mild range of significant impairment in the Communication domain and in the moderate range of significant impairment in the Daily Living and Socialization domains. (Exhibit K.)

24(d). The Autism Diagnostic Observation Schedule (ADOS), Module 3 and 4, was administered. Dr. Eagle noted:

> The ADOS is designed to elicit social and communicative behaviors and evaluate whether they are consistent with a diagnosis of autism or autistic spectrum disorder. As such, the scoring system is geared towards and describes indications of autism, not atypical variation of social and communicative behaviors that indicate some other type of disorder. [Claimant's] social and communicative behavior is clearly atypical, as a function of his psychosis. Therefore, while the ADOS scoring system can be used to represent the presence or degree of atypicality, it provides a less valid representation of the specific quality of atypicality. Complicating the matter further is the fact that [claimant] presents in a highly inconsistent manner, such that at times, he appears more engaged and communicative than others. Ironically, he appears most engaged and communicative when talking about delusional material. Thus, using the ADOS system of scoring, [claimant's] social interaction scores suggest somewhat less likelihood of autism, when a psychotic processes seems active, and more indicators of autistic-like behaviors when it is not. He also behaves differently when speaking in Mandarin to his mother and grandmother, and, as noted above, when working, one-on-one, with highly structured material. (Exhibit K.)

24(e). According to Dr. Eagle's observations, claimant's communication score falls short of the autism cut-off at the times when he does not act in a bizarre fashion or display stereotypical language and when he does use gestures to express, describe or emphasize what he wishes to communicate. Consequently, although claimant's combined communication and social interaction score exceed the cutoff for an ADOS classification of autism (due to his very limited reciprocal social behavior), he does not meet criteria for that classification, because his communication score falls short of the autism cut-off. Nevertheless, Dr. Eagle noted:

> A somewhat different picture emerges when the ADOS is scored on the basis of [claimant's] behavior when he is behaving in a psychotic fashion and/or communicating about delusional material, especially in Mandarin. Then the communication score meets the ADOS autism cut off, primarily due to the bizarre gestures, along with the limited reciprocity in his conversation. His reciprocal social interaction score exceeds the cut off for ADOS classification of autism spectrum but only hovers about the cut off [for] the classification for autism. This is because [claimant's] eye contact, facial expression, and even the quality of his social overtures seem relatively "normal" at these times. The combined score exceeds the cutoff for an ADOS classification of autistic spectrum, and just hovers at about the cut off for autism.

> These results suggest an ADOS classification of at least some type of autistic spectrum disorder, and possibly, albeit more tentatively, an ADOS classification of autism. This conclusion, however, must be qualified by some reservation about the likely limitations of the ADOS for assessing autism in an individual who also presents with psychosis. (Exhibit K.)

24(f). Dr. Eagle noted that, during the evaluation, it was apparent that claimant was "still suffering from a psychotic disorder, albeit without the confounding effects of heavy medication. Therefore, as was the case during the first assessment, the current situation involves the challenges of accessing evidence of a developmental disability which a psychotic process would likely obscure and of separating out the effects and characteristics of the developmental disability from the effect and characteristics of the psychosis." Dr. Eagle also mentioned the difficulty of interpreting claimant's history prior to the onset of his psychosis. According to Dr. Eagle, "At issue were both the reliability of the information . . . and the interpretation of the apparent differences in his behavior – specifically, whether they reflected environmental/emotional factors versus an intrinsic developmental disability. Alternative diagnoses of separation anxiety, attachment disorder, depression, adjustment disorder (to multiple moves, separations, and dramatic shifts in culture and language) and post-traumatic stress disorder were considered." Consequently, Dr. Eagle maintained that "there will have to be an element of conjecture in any conclusions drawn about whether or not [claimant] has an underlying developmental disability and if so, of what kind." (Exhibit K.)

25(g). Dr. Eagle diagnosed claimant with Schizophrenia, paranoid type, and PDD-NOS. She did note a differential diagnosis of Asperger's Disorder. (Exhibits D and K.)

26. On January 22, 2010, HRC sent a letter to claimant's mother, informing her that they had determined claimant was not eligible for regional center services. The letter further stated:

> It was the determination of the multidisciplinary team that [claimant] does not have an eligible condition according to California law and regulation such as an intellectual disability (mental retardation), cerebral palsy, epilepsy or autism or a condition similar to mental retardation requiring services like that of someone with mental retardation. Records show that prior to the onset of psychosis, [claimant] had average intelligence. We did find that he is in need of assistance with job training, independent living skills training and socialization outlets. As he is already under psychiatric care, you may consult with the psychiatrist/case manager regarding additional resources available to [claimant] through the Department of Mental Health. (Exhibit B.)

27. On February 19, 2010, claimant's mother filed a Fair Hearing Request, seeking a determination that claimant is eligible for services under the Lanterman Act. (Exhibit A.)

28. The evidence presented at the fair hearing failed to establish that claimant suffers from Autistic Disorder.

29. The evidence presented at the fair hearing did not establish that claimant suffers from a condition similar to mental retardation or requiring treatment similar to persons with mental retardation.

LEGAL CONCLUSIONS

1. Claimant did not establish that he suffers from a developmental disability entitling him to Regional Center services. (Factual Findings 1 through 29.)

2. Throughout the applicable statutes and regulations (Welf. & Inst. Code §§ 4700 - 4716, and Cal. Code Regs., tit. 17, §§ 50900 - 50964), the state level fair hearing is referred to as an appeal of the Service Agency's decision. Where a claimant seeks to establish his eligibility for services, the burden is on the appealing claimant to demonstrate that the Service Agency's decision is incorrect. Claimant has not met his burden of proof in this case.

3. In order to be eligible for regional center services, a claimant must have a qualifying developmental disability. As applicable to this case, Welfare and Institutions Code section 4512 defines "developmental disability" as:

> [A] disability which originates before an individual attains age 18, continues, or can be expected to continue, indefinitely, and constitutes a substantial disability for that individual, and includes mental retardation, cerebral palsy, epilepsy, autism, and disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for mentally retarded individuals, but shall not include other handicapping conditions that are solely physical in nature.

4. To prove the existence of a developmental disability within the meaning of Welfare and Institutions Code section 4512, a claimant must show that he has a "substantial disability." In assessing what constitutes a "substantial disability" within the meaning of section 4512, the following provisions are helpful:

California Code of Regulations, title 17, section 54001 states, in pertinent part:

(a) "Substantial disability" means:

> (1) A condition which results in major impairment of cognitive and/or social functioning, representing sufficient impairment to require interdisciplinary planning and coordination of special or generic services to assist the individual in achieving maximum potential; and
> (2) The existence of significant functional limitations, as determined by the regional center, in three or more of the following areas of major life activity, as appropriate to the person's age:
> (A) Receptive and expressive language;
> (B) Learning;
> (C) Self-care;
> (D) Mobility;
> (E) Self-direction;
> (F) Capacity for independent living;
> (G) Economic self-sufficiency.

In California Code of Regulations, title 17, section 54002, the term "cognitive" is defined as:

> [T]he ability of an individual to solve problems with insight, to adapt to new situations, to think abstractly, and to profit from experience.

5(a). In addition to proving a "substantial disability," a claimant must show that his disability fits into one of the five categories of eligibility set forth in Welfare and Institutions Code section 4512. The first four categories are specified as: mental retardation, epilepsy, autism and cerebral palsy. The fifth and last category of eligibility is listed as "Disabling conditions found to be closely related to mental retardation or to require treatment similar to that required for individuals with mental retardation." (Welf. & Inst. Code, § 4512.) This category is not further defined by statute or regulation.

5(b). Whereas the first four categories of eligibility are very specific, the disabling conditions under this residual fifth category are intentionally broad to encompass unspecified conditions and disorders. However, this broad language is not intended to be a catchall, requiring unlimited access for all persons with some form of learning or behavioral disability. There are many persons with sub-average functioning and impaired adaptive behavior; under the Lanterman Act, the Service Agency does not have a duty to serve all of them.

5(c). While the Legislature did not define the fifth category, it did require that the qualifying condition be "closely related" (Welf. & Inst. Code, § 4512) or "similar" (Cal. Code. Regs., tit. 17, § 54000) to mental retardation or "require treatment similar to that required for mentally retarded individuals." (Welf. & Inst. Code, § 4512.) The definitive characteristics of mental retardation include a significant degree of cognitive and adaptive

deficits. Thus, to be "closely related" or "similar" to mental retardation, there must be a manifestation of cognitive and/or adaptive deficits which render that individual's disability like that of a person with mental retardation. However, this does not require strict replication of all of the cognitive and adaptive criteria typically utilized when establishing eligibility due to mental retardation (e.g., reliance on I.Q. scores). If this were so, the fifth category would be redundant. Eligibility under this category requires an analysis of the quality of a claimant's cognitive and adaptive functioning and a determination of whether the effect on his/her performance renders him/her like a person with mental retardation. Furthermore, determining whether a claimant's condition "requires treatment similar to that required for mentally retarded individuals" is not a simple exercise of enumerating the services provided and finding that a claimant would benefit from them. Many people could benefit from the types of services offered by regional centers (e.g., counseling, vocational training or living skills training). The criterion is not whether someone would benefit. Rather, it is whether someone's condition *requires* such treatment.

6. In order to establish eligibility, a claimant's substantial disability must not be solely caused by an excluded condition. The statutory and regulatory definitions of "developmental disability" (Welf. & Inst. Code, § 4512 and Cal. Code. Regs., tit. 17, § 54000) exclude conditions that are *solely* physical in nature. California Code of Regulations, title 17, section 54000, also excludes conditions that are *solely* psychiatric disorders or *solely* learning disabilities. Therefore, a person with a "dual diagnosis," that is, a developmental disability coupled with either a psychiatric disorder, a physical disorder, or a learning disability, could still be eligible for services. However, someone whose conditions originate from just the excluded categories (psychiatric disorder, physical disorder, or learning disability, alone or in some combination), and who does *not* have a developmental disability would not be eligible.

7. Although Claimant maintains that he is eligible for regional center services, he currently does not have any of the qualifying diagnoses.

8. The DSM-IV-TR discusses Autism in the section entitled "Pervasive Developmental Disorders." (DSM-IV-TR, pp. 69 - 84.) The five "Pervasive Developmental Disorders" identified in the DSM-IV-TR are Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and PDD-NOS. The DSM-IV- TR, section 299.00 states:

> The essential features of Autistic Disorder are the presence of markedly abnormal or impaired development in social interaction and communication and markedly restricted repertoire of activity and interests. Manifestations of the disorder vary greatly depending on the developmental level and chronological age of the individual. Autistic Disorder is sometimes referred to as *early infantile autism, childhood autism,* or *Kanner's autism*. (Emphasis in original.)
>
> (*Id*. at p. 70.)

9. The DSM-IV-TR lists criteria which must be met to provide a specific diagnosis of an Autistic Disorder, as follows:

A. A total of six (or more) items from (1), (2) and (3), with at least two from (1), and one each from (2) and (3):

(1) qualitative impairment in social interaction, as manifested by at least two of the following:

(a) marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction

(b) failure to develop peer relationships appropriate to developmental level

(c) a lack of spontaneous seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest)

(d) lack of social or emotional reciprocity

(2) qualitative impairments in communication as manifested by at least one of the following:

(a) delay in, or total lack of, the development of spoken language (not accompanied by an attempt to compensate through alternative modes of communication such as gestures or mime)

(b) in individuals with adequate speech, marked impairment in the ability to initiate or sustain a conversation with others

(c) stereotyped and repetitive use of language or idiosyncratic language

(d) lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level

(3) restricted repetitive and stereotyped patterns of behavior, interests, and activities, as manifested by at least one of the following:

(a) encompassing preoccupation with one or more stereotyped and restricted patterns of interest that is abnormal either in intensity or focus.

(b) apparently inflexible adherence to specific, nonfunctional routines or rituals.

(c) stereotyped and repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements)

(d) persistent preoccupation with parts of objects

B. Delays or abnormal functioning in at least one of the following areas, with onset prior to age 3 years: (1) social interaction, (2) language as used in communication, or (3) symbolic or imaginative play.

C. The disturbance causes clinically significant impairment in social, occupational, or other important areas of functioning.

(*Id*. at p. 75.)

10. In this case, Claimant alleges that he should be eligible for regional center services under the qualifying disability of autism. However, none of the psychologists who evaluated claimant diagnosed him with Autistic Disorder. According to the DSM-IV-TR, specific clinical criteria must be evident to diagnose Autistic Disorder. While Claimant does manifest some autistic characteristics, such as social impairment, varying degrees of communication impairment, and some atypical behaviors, no psychologist specifically found that he satisfied the required number of elements within the autism criteria of the DSM-IV-TR to diagnose him with Autistic Disorder. Consequently, Claimant has not established that he is eligible for regional center services under the diagnosis of autism.

11. Although claimant does demonstrate some deficits in cognitive functioning and in adaptive functioning, the evidence did not demonstrate that he presents as a person suffering from a condition similar to Mental Retardation. Moreover, the evidence did not establish that claimant requires treatment similar to that required for mentally retarded individuals. Based on the foregoing, claimant has not met his burden of proof that he falls under the fifth category of eligibility.

12. The weight of the evidence did not support a finding that claimant is eligible to receive regional center services.

ORDER

WHEREFORE, THE FOLLOWING ORDER is hereby made:

Claimant's appeal of the Service Agency's determination that he is not eligible for regional center services is denied.

NOTICE

This is the final administrative decision; both parties are bound by this decision. Either party may appeal this decision to a court of competent jurisdiction within 90 days.

DATED: August 22, 2011

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JULIE CABOS-OWEN
Administrative Law Judge
Office of Administrative Hearings